Supreme Court, U.S.
FILED
JUN 13 1997
OFFICE OF THE CLERK

No. 96-1802

In The

Supreme Court of the United States

October Term, 1996

DONNA DURHAM,

Petitioner,

vs.

HEALTH NET, a California Corporation, THE RESTAURANT ENTERPRISES GROUP INC. EMPLOYEE BENEFIT PLAN, *et al.*,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

WILLIAM J. TAYLOR
Counsel of Record
ROBERT M. CHILVERS
JEANNIE M. ATWOOD
CHILVERS & TAYLOR, PC
Attorneys for Respondents
2030 Franklin Street
Suite 220
Oakland, CA 94612
(510) 444-7744

Of Counsel:

FIROUZEH LIANN GOHARI
VOGT, MEADVILLE & SWALLOW
21600 Oxnard Street
Suite 2000
Woodland Hills, CA 91367-4967

71307 (800) 3 APPEAL • (800) 5 APPEAL • (800) BRIEF 21 Lutz Appellate Services, inc.

22 pp

QUESTIONS PRESENTED FOR REVIEW

1. Does the failure to seek injunctive relief available under ERISA to secure medical treatment at a time when medically eligible preclude a later filed claim that seeks to invoke *Varity Corp. v. Howe*, 516 U.S. __, 116 S. Ct. 1065 (1996) to recover the money value of medical treatment that was never obtained?

2. Are the ERISA remedies that are available for injunctive relief to secure medical treatment so inadequate as to allow a later filed claim under *Varity Corp. v. Howe*, 516 U.S. __, 116 S. Ct. 1065 (1996) to recover the money value of medical treatment that was not obtained?

3. Does ERISA authorize a private right of action against an HMO to recover the dollar value of medical treatment that was never obtained and for which the beneficiary subsequently became medically ineligible?

4. Does ERISA authorize a private right of action to recover money measured as the dollar value of medical treatment that was not obtained by re-labeling the request for money damages as seeking "restitution" or other forms of "equitable relief"?

5. Is Petitioner's claim for injunctive relief moot?

STATEMENT OF INTERESTED PARTIES

Pursuant to Rule 29.6, Rules of the Supreme Court of the United States, Respondents hereby identify Health Systems International, Inc. ("HSI"), a public company traded on the New York Stock Exchange ("NYSE"), as the parent company of Respondent Health Net during the proceedings in the Ninth Circuit below. Since the Ninth Circuit's decision HSI has merged with another publicly traded company, Foundation Health Corp. The merged entity, which is Health Net's ultimate parent corporation, is now known as Foundation Health Systems, Inc. and is traded on the NYSE. The nonwholly owned subsidiaries of Foundation Health Systems, Inc. are San Luis Valley Physicians Service Corp., Limited, a Colorado corporation; QualMed Plans for Health of Pennsylvania, a Pennsylvania corporation; Integrated Pharmacy Systems, Inc., a Pennsylvania corporation; Foundation Health (Unlimited), United Kingdom; Mednet Europe, United Kingdom; and Gem Holding Corporation, a Utah corporation. The other respondent, The Restaurant Enterprises Group Inc. Employee Benefit Plan is a private employee welfare benefit trust. Petitioner, Ms. Donna Durham, is an individual residing in Northern California. No other parties appeared in the case in the District Court or on appeal.

TABLE OF CONTENTS

	Page
Questions Presented for Review	i
Statement of Interested Parties	ii
Table of Contents	iii
Table of Citations	iv
Statement of the Case	1
Reasons for Denying the Writ	4
I. There Is No Direct And Apparent Conflict Between The *Varity* Decision And This Case.	4
A. *Varity* Is Distinguishable And The Court's Decisions In Cases Like *Russell*, *Mertens*, And *Pilot Life* Apply.	5
1. Petitioner Seeks Damages, Not Equitable Relief	5
B. The Court's Decision In *Russell*, Distinguished In *Varity*, Governs This Case.	6
C. Even Assuming *Varity* Applied, The Question Of Appropriate Equitable Relief Is Not Squarely Presented.	7

Contents

Page

II. It Is Not The Court's Role To Review Unpublished Decisions For Errors In Individual ERISA Benefit Determinations. 8

III. The Relief Petitioner Seeks Is Contrary To ERISA's "Carefully Integrated" Civil Enforcement Scheme. 10

IV. The Result Below Would Not Immunize ERISA Violations And Leave Health Plan Members Without Redress. 12

Conclusion 15

TABLE OF CITATIONS

Cases Cited:

Barnett v. Kaiser Foundation Health Plan, Inc., 32 F.3d 413 (9th Cir. 1994) 13

Bernards v. United of Omaha Life Ins. Co., 987 F.2d 486 (8th Cir. 1993) 13

Davenport v. Blue Cross of California, 52 Cal. App. 4th 435, 60 Cal. Rptr. 2d 641 (1997) 3

Forsyth v. Humana, Inc., 1997 WL 271465 (9th Cir. (Nev.)) 7

Contents

Page

Kekis v. Blue Cross and Blue Shield of Utica-Watertown, Inc., 815 F. Supp. 571 (N.D.N.Y. 1993) 13

Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134 (1985) 6, 7, 10, 11

Mertens v. Hewitt Associates, 508 U.S. 248 (1993) 5, 6, 9, 11, 12

Pilkington PLC v. Perelman, 72 F.3d 1396 (9th Cir. 1995) 10

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) ... 5, 12

Sweeney v. Gerber Products Co. Med. Benefits Plan, 728 F. Supp. 594 (D. Neb. 1989) 13

Varity Corp. v. Howe, 516 U.S. __, 116 S. Ct. 1065 (1996) .....i, 4, 5, 6, 7, 8, 10, 11, 12, 13

White v. Caterpillar, Inc., 765 F. Supp. 1418 (W.D. Mo. 1991), *aff'd without opinion*, 985 F.2d 564 (1991) 13

Statutes Cited:

29 U.S.C. § 1132(a)(1) 6, 7, 11

29 U.S.C. § 1132(a)(3) 6, 7

29 U.S.C. §§ 1161-68 1

Contents

Page

29 U.S.C. § 1332(a)(1) 6, 7, 11, 13

Cal. Health & Safety Code § 1340, *et seq.* 2

Cal. Health & Safety Code § 1367, *et seq.* 2

Cal. Health & Safety Code § 1368, as amended 1995 Laws, 788 (Oct. 12, 1995) 2

Cal. Insurance Code § 740(g) 2

Cal. Insurance Code § 10198.7 8

Rules Cited:

Ninth Circuit Rule 36-3 9

Supreme Court Rule 10 9

Supreme Court Rule 10(c) 6, 9

Supreme Court Rule 12.7 1

Other Authorities Cited:

Justice Harlan, *Manning the Dikes,* 13 Record of N.Y.C. Bar Assn. 541 (1958) 10

R. Stern, E. Gressman, S. Shapiro & K. Geller, Supreme Court Practice (7th Edition 1993) 9

STATEMENT OF THE CASE

A restatement of the case is in order because Petitioner's rendition of the facts leaves out many details crucial to understanding the case and contains other assertions that are not supported in the record. As Petitioner has not seen fit to support her version of the "facts" with citation to the record, pursuant to Rule 12.7 of the Court Respondents cite the record on appeal using the same notation used in the Ninth Circuit.

The salient facts are few. Petitioner became a member of the Health Net health care service plan (hereinafter "Health Net") in January 1992. (CR 22, ER 1, ¶ 1)[1]. Her membership was through participation in the Restaurant Enterprises Group Inc. Employee Benefit Plan (hereinafter "Employee Plan") which was a fringe benefit provided through her employment. (CR 22, ER 1, ¶ 2). Her employment ended June 15, 1992, and she continued receiving medical benefits from Health Net through December 31, 1993, under COBRA[2]. (CR 22, ER 2, ¶¶ 4 & 5).

As a health maintenance organization (hereinafter "HMO"), Health Net provides health care benefits in a different manner than the traditional "health insurer" who provides indemnity insurance for health care treatments. An HMO operating under the "network" model like Health Net contracts with medical groups who in turn provide medical care. Rather than money,

---

1. The abbreviations "CR," "RT," "ER," and "SER" are used throughout to refer to the Clerk's Record (District Court Docket Summary), the Reporter's Transcript of the hearing on the summary judgment, the Excerpts of Record submitted by the Appellant in the Ninth Circuit, and the Supplemental Excerpts of Record submitted by the Appellees, respectively. Citations have been omitted and emphasis added in quotations unless otherwise noted.

2. The Consolidated Omnibus Budget Reconciliation Act of 1985, codified, as amended, at 29 U.S.C. §§ 1161-68.

the HMO provides access. It is a vehicle through which the beneficiary obtains health care treatment. The benefit contract with the HMO commits it to make access available for certain care and procedures through participating physicians and hospitals. If the member wants to partake of the benefits provided through Health Net, the member must use the health care providers and facilities within Health Net's "network." Generally, services received "out-of-network" are not within the scope of Health Net's "coverage." Thus, the benefits provided through Health Net are access to the medical treatments furnished to the member by the medical groups and facilities with which Health Net has contracted, not payment for care or reimbursement for care as are provided to the insured under health insurance.

HMOs like Health Net are heavily regulated by the State of California. All aspects of the operation of an HMO operating in California are actively monitored and continually regulated by the California Commissioner of Corporations and Department of Corporations (hereinafter "DOC"), not the Insurance Commissioner or the Department of Insurance. Cal. Health & Safety Code § 1340, *et seq.*; Cal. Insurance Code § 740(g) (Insurance Code inapplicable to HMOs). Among the aspects regulated by the DOC are the marketing of the HMO to employer groups and to prospective members; the contracts with the physicians, hospitals and providers utilized by the HMO to provide health care; and the finances of the HMO. Since January 1, 1996, the DOC has also been charged with providing a forum for review of disputes over individual health care benefit decisions. Cal. Health & Safety Code § 1368 as amended, 1995 Laws, 788 (Oct. 12, 1995). In addition, the California Legislature has defined the minimum package of health care benefits that must be provided by an HMO operating in California. Cal. Health & Safety Code § 1367, *et seq.* High dose chemotherapy treatment/autologous bone marrow transplant (hereinafter

"HDCT/ABMT") is not among the benefits that are required to be provided. Of course, HMOs like Health Net can and do contract to provide more than the minimum benefits package required.

On September 14, 1992, petitioner was diagnosed with breast cancer. (CR 22, ER 2, ¶ 6). She requested authorization from Health Net for HDCT/ABMT in November, 1992. (CR 22, ER 2, ¶ 7). The request was denied. (CR 22, ER 2, ¶ 8). Petitioner made a second request for authorization in March, 1993. (CR 22, ER 2, ¶ 9). This request was also denied. (CR 22, ER 2, ¶ 10).

Petitioner did not file suit to seek to compel Health Net to provide HDCT/ABMT. (CR 35, SER 1-13). Nor did she seek to undergo HDCT/ABMT at her own expense, and she did not incur *any* cost in connection with HDCT/ABMT. (CR 22, ER 2, ¶¶ 12 & 13). Subsequently, her condition changed and HDCT/ABMT was not medically indicated.[3] (CR 22, ER 3, ¶ 15). Her cancer is now in remission, and only monitoring is medically indicated. (CR 35, SER 17:12-22, RT at 14:12-22). She is not presently a candidate for HDCT/ABMT treatment, and was not at the time she filed suit. (CR 22, ER 3, ¶ 15).

---

3. The unsworn assertions made at footnote 3 of the Petition that Ms. Durham's cancer has reappeared are not in the record and cannot be considered here. Moreover, skepticism is in order for several reasons. At oral argument in the Ninth Circuit Mr. Tysch asserted this had coincidentally happened as well in the companion case consolidated for argument. Counsel's penchant for citing "unsworn averments in a memorandum of law" has been judicially recognized, and such statements disregarded, elsewhere. *See Davenport v. Blue Cross of California*, 52 Cal. App. 4th 435, 454; 60 Cal. Rptr. 2d 641, 651-52 (1997). That court also noted additional issues presented to it regarding claims of counsel's problems complying with court rules regarding evidence and his obligations as an officer of the court. *Id.* at 52 Cal. App. 4th at 442 & fn. 1, fn. 2; 60 Cal. Rptr. 2d at 644 & fn. 1, fn. 2.

Despite the fact that HDCT/ABMT was no longer of any use to her, and despite the fact that she never paid for HDCT/ABMT treatment from other sources, petitioner sought monetary damages as set forth in the First Amended Complaint. (CR 16, SER 8, ¶¶ 24, 28, 30 & 37).

Procedurally, the suit started in March, 1994 in California Superior Court and was removed to District Court. (CR 1, ER 21, ¶ 16). The amended federal court complaint had three counts: (1) a breach of contract claim; (2) a claim for "equitable relief"; and (3) a claim for attorneys' fees. (CR 16, SER 1-13). At an early status conference the District Court invited the parties to address by summary judgment the issue whether the relief sought was available under ERISA. The District Court concluded it was not, and granted Health Net's motion for summary judgment. As the claims against the Employee Plan were premised on the claims against, and the relief sought from, Health Net, judgment was entered dismissing the case. Petitioner appealed and the Ninth Circuit affirmed. The matter is now before this Court on Petition for Certiorari.

REASONS FOR DENYING THE WRIT

I.

THERE IS NO DIRECT AND APPARENT CONFLICT BETWEEN THE *VARITY* DECISION AND THIS CASE.

Petitioner seeks review of the "conflict" between this case and the Court's recent decision in *Varity Corp. v. Howe*, 516 U.S. __, 116 S. Ct. 1065 (1996). However, that case is wholly distinguishable from the instant case, and there is no "conflict". Moreover, there has been no showing that the purported "conflict" is both direct and apparent. Finally, review by the Court should not be squandered on a case of this nature — an

unpublished decision concerning the accuracy of an individual health benefit determination.

A. *Varity* Is Distinguishable And The Court's Decisions In Cases Like *Russell, Mertens,* And *Pilot Life* Apply.

1. *Petitioner Seeks Damages, Not Equitable Relief*

The decision in *Varity Corp.* is distinguishable on several grounds. First, what Ms. Durham seeks is not equitable relief but compensatory damages. Her ERISA complaint below had three counts: breach of contract, "equitable relief" and a claim for attorneys' fees. The relief sought was an award of the monetary value of the HDCT/ABMT. No claim of breach of fiduciary duty was made[4] and no specific relief other than an order for the payment of money was ever raised. That is what was requested in both the District Court and on appeal. The only relief that Petitioner ever identified or requested was that Respondents be ordered to pay money to Petitioner in the amount of the value of the medical treatment benefit they claim was wrongfully denied. While Petitioner has called this "restitution," "disgorgement" of "unjust enrichment," "constructive trust" and now just "equitable relief," the Court of Appeals found the relief sought was a claim for "compensatory damages." That mixed ruling of law and fact provides a valid distinction from *Varity.* It is also consistent with the Court's decision in *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41 (1987) which held there is no private right of action under ERISA to recover money for improper claims handling including that arising from delay in a benefits decision. Moreover, even assuming the Ninth Circuit erred in ruling that petitioner's claim was one for compensatory damages, the ruling does not provide the direct and apparent conflict that

---

4. At oral argument on the summary judgment motions, in response to questioning by the Court, Petitioner clearly stated she was not making a claim based on alleged breach of fiduciary duty. RT at 2:18-3:10.

Rule 10(c) requires to merit the Court's review. Rather, it is a ruling that is fact-dependent and case-specific.

B. The Court's Decision In *Russell*, Distinguished In *Varity*, Governs This Case.

The result below is consistent with and controlled by the Court's decisions in *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) and *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), which in turn were distinguished by the Court in arriving at its decision in *Varity*. In *Varity* the Court noted that:

> *Russell* involved a complicating factor not present here, in that another remedial provision (subsection one) already provided specific relief for the sort of injury the plaintiff had suffered (wrongful denial of benefits). . . .

Varity, 516 U.S. at __, 116 S. Ct. at 1076.

That distinction holds here as well. This case is about a denial of benefits plain and simple. Petitioner had a remedy under Section 502(a)(1) of ERISA (codified at 29 U.S.C. § 1332(a)(1)) to contest the denial of benefits at the time and to seek an order directing Health Net to authorize coverage for the treatment at issue. Despite having ample time to bring a suit for injunctive relief compelling Health Net to reverse its decision, Petitioner did nothing until filing suit more than a year and a half after the initial denial by Health Net. By then injunctive relief was moot as Petitioner's cancer was in remission. Petitioner now seeks equitable relief pursuant to 29 U.S.C. § 1132(a)(3) as interpreted by *Varity*. However, where section

1132(a)(1) provides an adequate remedy, equitable relief under section (a)(3) is inappropriate.[5]

C. Even Assuming *Varity* Applied, The Question Of Appropriate Equitable Relief Is Not Squarely Presented.

Petitioner argues that the conflict is so squarely presented as to justify review. In fact, even assuming *arguendo* that *Varity* applies, the remedy sought in this case is not available under the holding in that case. In any event, the "absence" of a remedy in the instant case does not "squarely present" a mandate for fashioning a remedy here. *Varity* authorizes only "appropriate equitable relief." *Varity*, 516 U.S. at ___, 116 S. Ct. at 1079. Thus, the Court noted that:

> [W]here [as here] Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief, in which case such relief normally would not be "appropriate." *Cf. Russell, supra*, at 144.

Id.

Here, the further relief sought is not appropriate in view of the remedy that was available and unused for anywhere from five to eighteen months. Moreover, injunctive relief for the denial of benefits is moot. Sometime over the year and one-half period between the benefit denial decision and the filing of suit, Petitioner's cancer was in remission and injunctive relief became moot. On the record of this case, at all times from initiation of suit Petitioner has been medically ineligible for the treatment at

---

5. Indeed, the Ninth Circuit has recognized this holding of *Varity*. *Forsyth v. Humana, Inc.*, 1997 WL 271465 (9th Cir. (Nev.)).

issue.[6] Moreover, as Petitioner had left her employment before the initial diagnosis of breast cancer and thereafter terminated her health plan coverage, there is no basis on which Health Net and the ERISA plan could be currently ordered to authorize treatment to someone no longer participating in the ERISA health plan. Any injunctive relief was moot once her cancer was in remission and she left the plan. Therefore, there is no remedy "appropriate" under *Varity*.

II.

IT IS NOT THE COURT'S ROLE TO REVIEW UNPUBLISHED DECISIONS FOR ERRORS IN INDIVIDUAL ERISA BENEFIT DETERMINATIONS.

Review by this Court is a scarce resource. Over the years the Court has developed an extensive jurisprudence regarding the exercise of its discretion regarding which cases to review.

---

6. Even assuming the new "facts" advanced in footnote 3 of the Petition, the case is still moot. Under California law any reappearance of Petitioner's cancer is the basis for a new health benefits claim under the coverage she then has. Of course, as Petitioner left her employment prior to the initial diagnosis of cancer she could not continue her coverage under the ERISA plan past the point decreed under COBRA. We do not know whether or not she had other coverage after that point. Under California's current law, had she sought conversion coverage she could not be precluded from joining a health plan based on her "pre-existing condition." Cal. Ins. Code § 10198.7. Once new coverage was in place, the reappearance of her cancer, if indeed it occurred, would have been dealt with as a new claim by the health insurer or HMO, if any, then providing coverage. The legal claim for injunctive relief sought in March 1994 as to the payment of the value of the treatment based on the benefit claim that was initially denied in November 1992 is still moot. The alleged re-appearance of cancer in late 1996 does not change the circumstance that at all times that she was covered by Health Net and the ERISA plan after the remission of her cancer, Petitioner was not medically eligible for HDCT/ABMT treatment.

This case does not satisfy any of the criteria for grant of *certiorari*. There are no "special and important reasons" to review this case. Rule 10, Rules of the Court. The Petition should be denied for this reason alone.

The sole basis advanced for review is that the Ninth Circuit's unanimous unpublished decision has been decided in "conflict" with a decision of the Court. Even assuming for the sake of argument that there were such a conflict, there has been no showing that the conflict concerns "an important federal question." Rule 10(c), Rules of the Court. There is also considerable doubt whether an unpublished ruling, which is not even binding precedent in the Ninth Circuit[7], can ever rise to the nature of the conflicting decision that is contemplated to fit within Rule 10(c). The function of this Court has never been to review unpublished Court of Appeal decisions to correct claimed deviations from decisions of the Court. Rather, review under Rule 10(c) requires "conflict" that is both "direct and apparent." R. Stern, E. Gressman, S. Shapiro & K. Geller, Supreme Court Practice (7th Edition 1993) at p. 174. The underlying premise of that standard and the Rule is that the decision to be reviewed will cause on-going problems in the lower courts if not addressed by the Court. Here, there will be no on-going problems with the application of the Court's decision in the Ninth Circuit or elsewhere. It is not a legal precedent and cannot be cited in any other case.

Respondents submit there are no special and important reasons for granting the Petition. It is not the function of this Court to review the accuracy of a denial of an individual ERISA medical benefit claim set forth in an unpublished Court of Appeals decision. One principle on which the Court operates is that the fact that a case "may have been wrongly decided as

---

7. Ninth Circuit Rules, Rule 36-3.

between the parties" is not enough.[8] That should be doubly the case where the error concerns the case-specific question of the availability of equitable relief set out in an unpublished decision. The Petition should be denied.

III.

THE RELIEF PETITIONER SEEKS IS CONTRARY TO ERISA'S "CAREFULLY INTEGRATED" CIVIL ENFORCEMENT SCHEME.

ERISA is a " 'comprehensive and reticulated statute,' the product of a decade of congressional study . . . ."[9] Both the "remedies created by ERISA and the parties expressly authorized to seek them [are] exclusive."[10] The statutory scheme sets forth "six carefully integrated civil enforcement provisions."[11] Petitioner's arguments for review are premised on a mistaken, overly expansive reading of *Varity*.

The claimed "conflict" with *Varity* hinges on the "inadequate" remedy and the contention that *Varity* allows "the fashioning of appropriate equitable relief . . . where no other adequate relief is otherwise available." Petition at p. 5. That is not an accurate reading of *Varity*. If it were, *Varity* would be a license to re-write the ERISA remedial scheme. Petitioner's argument boils down to the proposition that whenever a litigant in a particular case finds the ERISA remedial provisions stand

---

8. Justice Harlan, *Manning the Dikes*, 13 Record of N.Y.C. Bar Assn. 541, 551 (1958).

9. *Mertens, supra*, 508 U.S. at 251.

10. *Pilkington PLC v. Perelman*, 72 F.3d 1396, 1398 (9th Cir. 1995).

11. *Russell, supra*, 473 U.S. at 146.

in the way of a particular item of relief (here the award of the monetary value of a benefit denied), the Court is free to invoke a "catchall" provision and "fashion appropriate equitable relief" to give the litigant what he or she wants. Not only does this run contrary to a number of the Court's decisions never mentioned in the Petition such as *Russell* and *Mertens*, but it also usurps the congressional function to set ERISA's remedial scheme. This improper invitation to re-write the statute is another reason for denying the writ.

With respect to benefit denials, Congress intended plan beneficiaries to resort to the remedy in Section 502(a)(1) (codified at 29 U.S.C. § 1132(a)(1)). Thus, it created a right to seek an immediate injunction in District Court and authorized the District Court to award attorneys' fees to further enhance and to encourage the use of this remedy. Under the interpretation of *Varity* urged by Petitioner, the Court should ignore all of the congressional study, the contours of Section 502(a)(1), and all of the Court's previous decisions regarding ERISA remedies and roam free to create additional remedies whenever it finds the congressional scheme "inadequate." Not only is no authority, other than *Varity*, advanced for this bold proposition; but none of the Court's other decisions, such as *Russell* or *Mertens* is even cited in the Petition. *Varity* does not grant such wide-ranging authority.

Petitioner's misinterpretation of *Varity* is highlighted by what is requested in this case. Petitioner, who slept on her rights and did not use the remedy Congress specifically provided, wants the Court to thereby conclude that a remedy for her claim is "unavailable" and "inadequate." That is not the holding of *Varity*.

Under the remedial schema intended by Congress she should have sought injunctive relief sometime in 1992 or 1993 to overturn the benefit decision. Congress made this remedy

"available," and, as Congress limited it, it must be deemed "adequate."

The specifics of the relief requested, a monetary award of the value of the treatment, also highlight Petitioner's misreading of *Varity*. To allow the lack of such relief to create a "conflict" with *Varity* would put *Varity* itself in direct conflict with a number of decisions of the Court. This Court has unequivocally held that Congress did not intend to grant compensatory damages for erroneous benefit decisions. *Mertens v. Hewitt, supra,* 508 U.S. at 255-259. It intended to provide an avenue to secure the benefits and no more. *E.g., Pilot Life Ins. Co. v. Dedeaux, supra,* 481 U.S. at 52. For the Court to nonetheless grant review to embark on a hunt for an "adequate" remedy every time this statutory scheme precludes an item of relief sought is neither an accurate reading of *Varity* nor a wise use of the *certiorari* jurisdiction. Furthermore, to invoke it in the circumstances of this particular case is not a sound exercise of the discretion to grant the writ. The Petition should be denied.

IV.

THE RESULT BELOW WOULD NOT IMMUNIZE ERISA VIOLATIONS AND LEAVE HEALTH PLAN MEMBERS WITHOUT REDRESS.

The focal point of the Petition is the claim that absent Court review and reversal there is no remedy for Petitioner, and this creates an unbearable "conflict" with *Varity*. The argument is made that this lack of remedy and conflict require the Court to fashion an equitable remedy. In fact, the disposition by the Court of Appeals does not leave HMO members who cannot afford to advance the costs of treatment with no remedy under ERISA.

There is a remedy under the statute for HMO members who

believe they are wrongfully denied benefits, whether the denial be perceived to be life threatening or otherwise. The remedy is for the member to sue promptly under 29 U.S.C. § 1132(a)(1) for an injunctive order to compel the plan to provide the medical treatment. Indeed, this avenue of redress is of more than theoretical substance as reported decisions suggest it has been used frequently. *E.g., Barnett v. Kaiser Foundation Health Plan, Inc.*, 32 F.3d 413 (9th Cir. 1994) (expedited trial regarding denial of liver transplant); *Bernards v. United of Omaha Life Ins. Co.*, 987 F.2d 486 (8th Cir. 1993) (ABMT denial; expedited summary judgment); *Kekis v. Blue Cross and Blue Shield of Utica-Watertown, Inc.*, 815 F. Supp. 571 (N.D.N.Y. 1993) (ABMT denial; preliminary injunction sought); *White v. Caterpillar, Inc.*, 765 F. Supp. 1418 (W.D. Mo. 1991), *aff'd without opinion*, 985 F.2d 564 (1991) (ABMT denial; preliminary injunction sought); *Sweeney v. Gerber Products Co. Med. Benefits Plan*, 728 F. Supp. 594 (D. Neb. 1989) (ABMT denial; preliminary injunction sought and combined with trial on the merits).

Contrary to Petitioner's assertion below that lawyers will not take such cases unless there is the added incentive that her claim for monetary relief will provide, lawyers have and will continue to pursue these cases. *E.g., Barnett, supra; Bernards, supra; Kekis, supra; White, supra; Sweeney, supra.* Congress has provided that such plaintiffs may recover attorneys' fees in appropriate cases, and any argument that this incentive is not enough should be addressed to Congress, not the courts. Denying the Petition will not leave ERISA beneficiaries without a remedy and will not create incentives for HMOs to wrongfully deny benefits. In sum, there is no good reason why "equity" considerations, whether they be general or specific to this case, should lead to review based on a conflict with *Varity*.

The District Court was aware of this avenue of redress and questioned Petitioner's counsel about it during argument on the

summary judgment motion. (CR 22, SER 20:21-21:27, RT at 19:21-20:7). As the record there reveals, petitioner had a period of at least five months where this remedy was open to her.[12] As there is no evidence in the record how long after March 1993 this "window" closed, the actual time might have been as long as a year and a half. No explanation was or could be given that this opportunity was insufficient. It is what the statute provides, and this Court should not create an additional, unauthorized remedy.

---

12. As argued below, petitioner slept on her rights from at least November 1992. (CR 22, SER 18:14- 19:11, RT 15:14- 16:11). The record shows that there was a period from at least November 1992 through March 1993 that she could have brought and resolved a claim for injunctive relief. *Id.* Approximately one and a half years later she brought the instant suit.

CONCLUSION

Based on the foregoing, the Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

WILLIAM J. TAYLOR
Counsel of Record
ROBERT M. CHILVERS
JEANNIE M. ATWOOD
CHILVERS & TAYLOR, PC
Attorneys for Respondents
2030 Franklin Street, Suite 220
Oakland, CA 94612
(510) 444-7744

Of Counsel:

FIROUZEH LIANN GOHARI
VOGT, MEADVILLE & SWALLOW
21600 Oxnard Street
Suite 2000
Woodland Hills, CA 91367-4967